



MEDICAID LONG-TERM SERVICES AND SUPPORTS

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LONG TERM SERVICES AND SUPPORTS (LTSS) DEFINITION

"Long-term services and supports provide assistance with activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals, managing medication, and housekeeping). Long-term services and supports include, but are not limited to, nursing facility care, adult daycare programs, home health aide services, personal care services, transportation, and supported employment as well as assistance provided by a family caregiver."

[*Medicaid Long Term Services and Supports: A Primer*](#), Kaiser Family Foundation (May 2015)

ISSUE

Describe the types of long-term services and supports (LTSS) that are available through the state's Medicaid program and how individuals qualify for LTSS.

SUMMARY

LTSS provide individuals who are elderly or have disabilities with assistance with activities of daily living through home- and community-based services or institutional care (see sidebar).

Low-income seniors and individuals with disabilities may receive Medicaid coverage through HUSKY C. Individuals who meet the income and asset limit requirements for HUSKY C receive health care coverage for wellness and preventive services, as well as long-term services and supports. Individuals in need of LTSS may also receive services through one of the state's Medicaid waiver programs if they meet certain eligibility criteria.

Since the Supreme Court held in [*Olmstead v. L.C.*](#) (527 U.S. 581 (1999)) that states cannot discriminate against people with disabilities by offering them long-term care services only in institutions when they could be served in the community, Connecticut has taken steps to transition individuals, when possible, from institutional care to home-based and community care. To this end, the state

participates in the federal Money Follows the Person program, which provides federal funds to help states rebalance their long-term care systems to better support people living in institutions who want to live in the community instead.

A recent [report](#) by the legislative Long Term Care Planning Committee stated a goal of increasing the proportion of Medicaid LTSS recipients who receive home and community-based services instead of institutional care from 56% in 2012 to 75% in 2025.

HUSKY C ELIGIBILITY

In order to be eligible for HUSKY C, an individual must be (1) age 65 or older or (2) age 18 to 64 and either blind or living with a disability. The individual must also meet certain income and asset limits.

Income Limits and Spend-Down

As of July 2015, HUSKY C income limits for most non-institutionalized recipients are \$523.38 for an individual and \$696.41 for a married couple. A standard income disregard (i.e., income that does not count toward the income limit) of (1) \$337 applies to individuals and (2) \$404.90 applies to couples. (The income limits are slightly higher in southwestern Connecticut.) The monthly income limit for institutionalized individuals is \$2,199.

Individuals with income above the limit may still qualify by “spending down” their excess income on medical bills. Medicaid-covered nursing home residents generally must turn over any monthly income they receive (e.g., Social Security) to the home (minus a monthly personal needs allowance, currently \$60) and the Medicaid program pays the home the difference between that amount and the daily rate DSS sets for the home.

The amount of applied income takes into account whether the nursing home resident has a spouse in the community. Under federal Medicaid rules, these spouses are entitled to receive a portion of the resident's income, which is called the minimum monthly needs allowance (MMNA) ([42 USC § 1396r-5\(d\)\(3\)](#)). The MMNA, which varies from one individual to another, is calculated through a formula that takes into account the spouse's monthly shelter and utility costs. The federal government sets the minimum and maximum MMNA amounts, which for 2015 are \$1,991.25 and \$2,980.50, respectively.

Asset Limits and Transfers

A single individual on HUSKY C may retain up to \$1,600 in assets; a married couple may retain \$2,400. If a spouse is living in a nursing home, federal Medicaid law allows the spouse living in the community to keep some of the couple's assets to ensure that he or she does not become impoverished. Most of the remainder is used to pay for nursing home costs of the institutionalized spouse. Once the institutionalized spouse begins a continuous nursing home stay, federal law requires the couple's assets to be combined and divided in half. States establish community spouse protected amounts within federal minimum and maximum limits. (The community spouse protected amount is a portion of the couple's assets the spouse in the community may keep in order not to impoverish him or herself.) Under current state law, the spouse can keep the greater of (1) the federal minimum (\$23,844 in 2015) or (2) half of the couple's combined assets, up to the federal maximum (\$119,220 in 2015). The spouse receiving long-term care may keep only a personal needs allowance, currently \$60 per month.

Federal law requires states to review asset transfers made by a person up to five years before he or she applies for Medicaid LTSS. The law presumes that any such transfer was made to qualify for Medicaid, but the presumption can be rebutted.

Applicants who make such transfers are subject to a penalty period (i.e., period before an applicant may receive assistance). The penalty period is calculated by dividing (1) the value of all assets transferred within the 60 months before application by (2) the average monthly cost to a private patient of nursing facility services.

Dual Eligibility

Many individuals who receive Medicaid long-term care are "dually eligible" for both Medicaid and Medicare. Medicare provides health coverage to (1) individuals over age 65 and (2) individuals under age 65 with disabilities after a 29-month waiting period. However, Medicare coverage for LTSS is limited. To qualify for post-acute nursing facility care coverage under Medicare, the recipient must be (1) age 65 or older, (2) under age 65 and have received Social Security disability insurance for more than 24 months, or (3) have end-stage renal cancer of amyotrophic lateral sclerosis. Medicare only covers post-acute nursing facility care for 100 days after a qualifying hospital stay and it does not cover personal care services. It covers home health services only for homebound individuals.

STATE'S MEDICAID WAIVER PROGRAMS

Acquired Brain Injury (ABI) and ABI II

The ABI and ABI II waivers provide non-medical, home and community-based services to help individuals with an ABI stay in the community. Eligible waiver recipients must (1) be between age 18 and 64, (2) be able to participate in service plan development with a DSS social worker or have a conservator do so, and (3) meet all Medicaid technical, procedural, and financial requirements. Both waivers provide a range of non-medical, home- and community-based services, to help maintain adults who have an acquired brain injury (not a developmental or degenerative disorder), in the community. Without these services, the adult would otherwise require placement in an institution.

Connecticut Home Care Program for the Elderly (CHCPE)

CHCPE provides home- and community-based services to individuals age 65 or older who receive, or would otherwise require, institutional care, in order to enable them to reside in the community. CHCPE has both Medicaid waiver-funded and solely state-funded components. The Medicaid waiver-funded components provide services to individuals who meet certain income and asset requirements and are (1) in need of long-term nursing home care or (2) at risk of hospitalization or short-term nursing home placement if they do not receive a moderate amount of home care. Services include homemaker, meals on wheels, assistive technology, and minor home modifications.

Personal Care Assistance (PCA)

The PCA Waiver provides PCA services to individuals with chronic, severe, and permanent disabilities in order to enable individuals to remain in the community who, based on their needs, would otherwise require institutionalization.

To qualify an individual must (1) be between age 18 and 64; (2) have a chronic, severe, and permanent disability that prevents him or her from completing at least two of the following activities without assistance: bathing, dressing, eating, transferring (e.g., getting into and out of bed or a wheelchair), and toileting; and (3) meet all technical, procedural, and financial Medicaid requirements.

Katie Beckett

The Katie Beckett waiver enables children with severe disabilities who otherwise would have to be institutionalized to live at home with needed medical supports. According to DSS, parents' income and assets are not factored into initial eligibility; DSS considers only the income and assets of the child.

The program's capacity depends on the availability of state and federal funding. It currently is closed and has a long waiting list.

DDS Home and Community Based Services (HCBS) Waivers

Through three different Medicaid waiver programs, DDS offers HCBS services to individuals with developmental or intellectual disabilities to enable them to live at home instead of in an institution. DSS oversees DDS' administration of the HCBS waivers.

The Comprehensive Supports waiver provides HCBS supports and services to individuals with intellectual or developmental disability who, without such services, would require institutionalization. Such services include, as appropriate, live-in caregivers, health care coordination, individualized day and home supports, assistive technology, and training and counseling services for unpaid caregivers.

The Employment and Day Supports waiver provides services to individuals who live at home or with their families and already have a strong support system. The population served includes children under age 21 with complex medical needs and individuals age 18 or older who require services such as career development and behavioral supports to remain at home. Additional services include community-based or individualized day support, interpreters, and transportation.

The Individual and Family Supports waiver provides services to individuals (1) age 18 or older with developmental disability and age three and older with intellectual disability and (2) who would need care in an intermediate care facility if not for such services. Services include live-in companions, environmental modifications, health care coordination, and individualized home or day supports.

More information about the Medicaid waiver programs is available at:

http://www.ct.gov/dss/lib/dss/pdfs/overview_of_connecticut_medicaid_waiver_programs_2_6_15.pdf.

HOME- AND COMMUNITY-BASED CARE

Olmstead v. L.C.

In 1996, the U.S. Supreme Court held in [*Olmstead v. L.C.*](#) that states cannot discriminate against people with disabilities by offering them long-term care services only in institutions when they could be served in the community, given state resources and other citizens' long-term care needs ([*Olmstead v. L.C.*](#), 119 S. Ct. 2176 (1999)). The Court found that the federal Americans with Disabilities Act requires states to provide community-based treatment for persons with disabilities when the (1) state's treatment professionals determine that such placement is

appropriate; (2) affected persons do not oppose such treatment; and (3) placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities. The Court suggested that states could demonstrate their compliance by creating a comprehensive, effectively working plan and having a waiting list for community services that moves at a reasonable pace.

State Long-Term Care Plans

Since the *Olmstead* decision, the state has established plans through the Long Term Care Planning Committee and DSS to enable more individuals in need of LTSS to remain in the community.

Long Term Care Planning Committee. The legislature established the Long Term Care Planning Committee in 1998 and charged it with creating a long-term care (LTC) plan for the elderly. The committee was also tasked with studying various elderly related issues. The scope of the plan was later expanded to include all people in need of long-term care, instead of just the elderly. The plan had to address the three components of the long-term care system: home and community-based services, supportive housing, and nursing facilities. The committee produced a preliminary plan in 1999 and its first formal plan in 2001. The committee has released updated reports every three years since the 2001 report was released. The [most recent report](#) was released in 2013 and it included among its recommendations that the state increase the proportion of (1) Medicaid LTSS recipients receiving home- and community-based services from 56% in 2012 to 75% in 2025 and (2) LTSS costs covered by private insurance and other private funds from 11.6% in 2010 to 25% in 2025.

DSS Strategic Rebalancing Plan. In 2011, the legislature passed a law that required the DSS commissioner to develop a strategic plan to rebalance Medicaid long-term care supports and services, including supports and services provided in-home, in a community-based setting, and in institutions.

DSS released the [2013-2015 Strategic Rebalancing Plan](#) in January 2013. The plan is designed to “rebalance” Connecticut’s Medicaid LTSS so that a greater proportion of recipients receive care at home than in institutions. The plan lists among its goals for accomplishing this result:

1. improving effectiveness and efficiency of Connecticut’s HCBS,
2. building capacity in the community workforce sufficient to sustain rebalancing goals,

3. increasing availability of accessible housing and transportation,
4. decreasing hospital discharges to nursing facilities among those requiring care after discharge, and
5. adjusting the supply of institutional beds and community services and supports based on demand projections.

The plan cites as funding sources federal Money Follows the Person (MFP) funds (see below) and an award from the federal State Balancing Incentive Payments Program. Through the latter program, the Center for Medicare and Medicaid Services provides grants to states to increase access to non-institutional LTSS.

MFP

MFP is a federal demonstration program designed to help states rebalance their long-term care systems to better support people living in institutions who want instead to live in the community. It serves the elderly and individuals with mental illness and developmental disabilities.

The federal program began in October 2007 and ends in September 2016. It supports states' efforts to transition people out of nursing homes and other institutional settings into less restrictive, community-based settings by offering them (1) enhanced Medicaid reimbursement for demonstration program services for the first 12 months the participant lives in the community (in Connecticut this means a 75% reimbursement instead of 50%) and (2) flexibility to provide supplemental support services, such as housing coordinators, that Medicaid does not normally cover. States are expected to reinvest the savings they realize by moving people out of nursing homes and into home- and community-based services.

DSS implemented MFP in December 2008. To participate in the program, a person must (1) have been institutionalized for at least 90 days and (2) meet Medicaid eligibility criteria. In addition, it cannot cost more to care for the person in the community than in an institution. After someone qualifies for MFP, DSS assesses the person's service needs, develops a care plan, and helps the person find housing and services.

HYPERLINKS

Connecticut Long-Term Care Planning Committee's *Balancing the System* report,
http://www.ct.gov/opm/lib/opm/hhs/ltc_planning_committee/ltc_plan_-_2013.pdf

Department of Social Services' *Strategic Rebalancing Plan*,
http://www.ct.gov/dss/lib/dss/pdfs/strategic_rebalancing_plan.pdf

Kaiser Family Foundation's *Medicaid Long Term Services and Supports: A Primer*,
<http://files.kff.org/attachment/report-medicare-and-long-term-services-and-supports-a-primer>

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